CHAPTER 12
SECTION 12.3

FIGURES

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FIGURE 12-12.3-1 GUIDELINES FOR POCS IN FILLING OUT CHAMPUS CLAIM FORMS

Most of the blocks on the CHAMPUS claim form (DD Form 2520) are self-explanatory. However, there are certain blocks which require special attention:

A. Block 1--Patient name. Only one patient per claim form. Be sure to use the name as it appears on the patient's ID card--or, as entered in DEERS.

B. Block 2--Be sure to enter the patient's birth date here. This is one of the essential identifiers for the DEERS data banks.

C. Blocks 3 and 10--Put the patient's daytime and evening phone numbers in these blocks so they may be called, if there's a problem on the claim.

D. Block 5a--For children up to age ten (10) without ID cards, use either parent's ID card information.

E. Block 5b and 5c--For active-duty ID cards, the effective date is the date the entitlement began; the issue date is the date the card is renewed, family member ID cards have the issue and expiration dates on the front in boxes 2 and 3. The effective dates are on the back of the card in box 15b. When a family member is not enrolled in DEERS, a copy of the front and back of the family member ID card must be sent with the claim.

F. Block 8--Be sure the military sponsor's or TRICARE Europe active duty member's Social Security number is entered. This is an essential "checkpoint" for DEERS.

G. Block 14a--If the patient is covered by any other health insurance plan, you must mark "yes," provide the information requested in 14a through 14e and attach documentation to show the claim has been processed by the other health insurance plan. If the patient is not covered by another health insurance plan, mark "No."

NOTE: This is not required on TRICARE Europe active duty member TRICARE Overseas claims.

H. Block 15--If the problem for which the patient went to the provider is work-related, military service-related, or was caused by an auto accident, you must check the

corresponding “yes” in Block 15. The contractor may follow up with some questions, to clarify potential worker's compensation coverage.

I. Block 17--Describe the illness or injury for which the patient received care.

J. Block 18--Signing the form. The patient must sign the form. If the patient is under 18, the parent or guardian must sign the form. Remember to include the current date in the required space.

NOTE: If the TRICARE Europe active duty member’s signature is not present on the claim form, the military command must submit a letter of explanation with the unsigned claim form prior to payment.

FIGURE 12-12.3-2 TRICARE OVERSEAS NETWORK PROVIDER FORM

(Please type or print legibly)

Provider Name: _____

Address: _____
(actual place of business) _____
_____
_____

Phone Number: (_____)_____

Fax Number: (_____)_____

Provider Major Specialty: _____

Mailing Address: _____
(Please indicate address _____
to which checks _____
should be mailed.) _____

Comments:
_____
_____
_____
_____

****

Approved by: _____ **Effective Date:** _____
_____
_____
_____

Date: _____

MCS Contractor Assigned Provider Number: _____

FIGURE 12-12.3-3 SAMPLE COVER LETTER FOR TRANSMITTING TRICARE OVERSEAS PROGRAM NON-AUTHORIZED CLAIMS REPORT TO LEAD AGENT

(Lead Agent Name)

(Address)

(Address)

Dear _____:

Enclosed is the weekly report of non-authorized claims received without authorization from TRICARE OVERSEAS enrollees.

Please review and indicate approval as appropriate. Please return the completed report and sign the authorization below. Upon receipt of the report, we will reprocess these claims according to your directions.

Please return the authorization to:

(Name - Contractor Representative)
(Name - Contractor)
(Address)
(Address)

Sincerely,

(Contractor Representative)

Authorized Signature:

The attached claims listing is approved as noted for reprocessing.

Signature _____

Title _____

Date _____

FIGURE 12-12.3-4 LEAD AGENT TRICARE OVERSEAS PROGRAM NON-AUTHORIZED OR NON-NETWORK PROVIDER CLAIMS REPORT

	SPONSOR	PATIENT	SPONSOR	PROVIDER		ACVDMIS			PURPOSE	REASON FOR REFERRAL *		APV.	
ICN	SSN	NAME	NAME	NAME AND ADDRESS	DATES	ID CODE	ICD9	CPT-4	VISIT	A	P	Y	N
97360 DE 00001	123 45 6789	Smith, Ann S.	Smith, John M.	Bauman, Peter HERDSTR 13 Donauschingn De	11-01-97-11-15-97								
97360 GB 00002	987 65 4321	Jones, Sally	Jones, Tom M.	Shepherd, Cameran *4TROON Dr Bridge of Weir GB	11-02-97-11-05-97								

*A = Authorization
P = Non-Network Provider

FIGURE 12-12.3-5 COUNTRIES NOT REQUIRING AUTHORIZATION FOR CARE

A. TRICARE Europe Countries Not Requiring Authorization For Care

All countries except Belgium, Germany, Italy, Spain, Turkey and the United Kingdom.

B. TRICARE Pacific Countries Not Requiring Authorization For Care

All countries except for Japan and Korea.

C. TRICARE Latin American Countries Not Requiring Authorization For Care

All countries.